

United States General Accounting Office

GAO

AD-A280 865



Report to the Administrator, Health
Care Financing Administration,
Department of Health and Human
Services

March 1990

MEDICARE AND MEDICAID

More Information
Exchange Could
Improve Detection of
Substandard Care



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Human Resources Division

B-237781

March 7, 1990

Gail R. Wilensky
Administrator, Health Care
Financing Administration
Department of Health and Human Services



Dear Ms. Wilensky:

As part of an earlier review of the management of the peer review organization (PRO) program, we observed that PROs, Medicare carriers, and state Medicaid agencies share a similar responsibility—that of ensuring that providers of medical care are reimbursed only for those services that are medically necessary. PROs and state Medicaid agencies are also responsible for determining whether services provided to beneficiaries meet professionally recognized standards of quality. In carrying out these responsibilities, the entities sometimes review services provided by the same physicians and may independently identify problems with the services provided by such physicians.

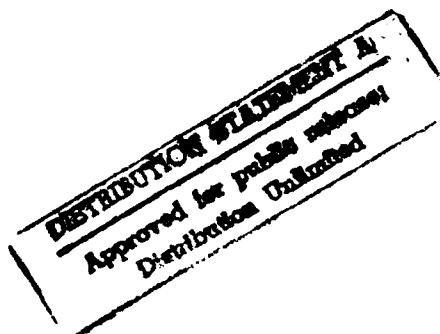
We found that PROs, Medicare carriers, and state Medicaid agencies do not routinely exchange information about physicians they have identified as providing unnecessary or poor-quality care. We believe that the exchange of such information would enhance the ability of these entities to detect patterns of such care in the Medicare and Medicaid programs. This in turn could shorten the time needed to initiate action to change the behavior of the physicians responsible for these problems.

We found no legal restrictions to the exchange of information among the review entities involved and note that the Health Care Financing Administration (HCFA) has already taken steps to require PROs to supply such data to state bodies responsible for licensing physicians. We believe HCFA should take similar steps to require PROs, carriers, and state Medicaid agencies to exchange data on problem providers.

In a May 1988 report,¹ we identified the need for better coordination among Medicare review entities on review findings related to quality of care. We recommended that the Administrator of HCFA be required to develop guidelines to coordinate the systematic and timely reporting by carriers and intermediaries to PROs of some possible quality-of-care problems. This report discusses one way in which this recommendation could be implemented.

¹Medicare: Improving Quality of Care Assessment and Assurance (GAO/PEMD-8-10, May 2, 1988).

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Background

HCFA, under the Department of Health and Human Services (HHS), is responsible for assuring that the Medicare and Medicaid programs pay only for medically necessary care that meets professionally recognized standards of quality. To help assure compliance with Medicare quality-of-care and reimbursement requirements, HCFA contracts with Medicare carriers, intermediaries, and PROs to conduct reviews of Medicare claims. State Medicaid agencies are responsible for performing reviews of Medicaid claims, and HCFA is responsible for assessing the adequacy of state efforts.

Medicare Review Entities

HCFA contracts with insurance companies, generally called intermediaries under part A and carriers under part B, to help administer the Medicare program. Intermediaries process and pay claims for inpatient hospital services under part A and for outpatient hospital services under part B. They are responsible for prepayment review of all claims they receive, which includes ensuring that services are covered, that the claims are not duplicates, and that numerous other payment criteria have been met. Carriers process and pay part B claims from physicians and other noninstitutional providers. In addition, carriers determine whether medical services provided to beneficiaries are medically necessary, appropriate, and reflect efficient use of available health services and facilities.

PROs are responsible for reviewing inpatient hospital care, skilled nursing facility care, and ambulatory care (in certain settings) to assure that Medicare beneficiaries receive only medically necessary care of a professionally recognized standard of quality. When PROs find unnecessary hospital admissions or quality-of-care problems, they may intensify their reviews of the responsible physician's past and future claims (that is, review all or a sample of such claims for a designated period of time) to identify whether corrective action is needed. Such corrective action may include intensifying the review, educating the physician, developing a corrective action plan, or recommending that the Office of Inspector General (OIG) impose a sanction.

Medicaid Review

The Social Security Act requires states to operate medical necessity and quality-of-care control programs to protect their Medicaid programs and Medicaid beneficiaries. When state Medicaid agencies identify aberrant providers, they pursue corrective actions similar to those in the Medicare program—denying payment or recouping amounts paid, educating providers, developing corrective action plans, or pursuing sanctions.

State Medicaid agencies may also refer physicians with quality-of-care problems to state medical licensing boards.

Sanctions

Medicare review entities can refer providers to the HHS OIG for possible sanction when measures to correct their inappropriate behavior are ineffective, or when the behavior constitutes a threat to the health and safety of beneficiaries. Sanctions may be either a monetary penalty, exclusion from the program, or both. State Medicaid agencies are empowered to exclude providers from the program for utilization or quality problems and for engaging in fraudulent billing practices, although they must inform the OIG of such actions. However, as agreed with the attorney general, only the OIG may impose penalties under the civil monetary penalty authority of the act. Exclusion from either program may result, and in some circumstances must result, in exclusion from the other program as well.

Objectives, Scope, and Methodology

The objectives of this review were to (1) determine whether PROs, Medicare carriers, and state Medicaid agencies reviewed services provided by the same physicians; (2) determine if these review entities regularly exchanged information on such physicians who were found to provide unnecessary or poor-quality care; and (3) identify any legal restrictions on such exchanges.

We performed work at HCFA headquarters in Baltimore, and at PROs, carriers, Medicaid agencies, and physician licensing boards in three states (California, North Carolina, and Virginia). We interviewed HCFA, PRO, carrier, state Medicaid, and state physician licensing board officials about their policies and practices regarding exchange of information on poorly performing physicians. We also reviewed applicable laws, regulations, manuals, and other relevant documents.

We performed our work from December 1987 to August 1988 in accordance with generally accepted government auditing standards.

Same Physicians Reviewed by PROs, Carriers, and State Medicaid Agencies

It is not uncommon for a physician to treat Medicare and Medicaid beneficiaries in both inpatient and outpatient settings. Thus, it is possible that the necessity and quality of the medical care provided by such a physician could be reviewed by three different entities—the PRO for care provided Medicare beneficiaries in the inpatient setting, the Medicare carrier for treatment provided in the outpatient setting, and the state

Medicaid agency for treatment provided to Medicaid beneficiaries in any setting.

We did not attempt to determine nationally how frequently the same physician comes under the purview of more than one of these review entities. To illustrate that this does happen, however, we requested Medicare carriers and state Medicaid agencies in three states (California, North Carolina, and Virginia²) to provide us with the names of physicians whom they had identified as having provided unnecessary or poor-quality care to program beneficiaries. Through this process, we compiled a list of 205 physicians named by either the carrier, the state Medicaid agency, or both. We then asked the PRO with review jurisdiction over each of the three states to determine if any of the physicians in question were also subject to their review, and, if so, whether they had been identified as providing unnecessary or poor-quality care. The results of our analysis are summarized in table 1.

Table 1: Physicians Identified as Providing Substandard Care

Review entity	Physicians identified	Physicians subject to PRO review	Problem physicians identified by PRO
Carrier	140	78	35
State Medicaid agency	62	36	17
Carrier and state Medicaid agency	3	2	2
Total	205	116	54

As can be seen in table 1, of the 205 physicians identified by a Medicare carrier or a state Medicaid agency as having provided unnecessary or poor-quality care, 116 (about 57 percent) were also subject to PRO review. Further, the three PROs told us that of the 116 physicians, they had identified 54 as having either utilization or quality problems or both. Thus, about 26 percent of the 205 physicians in three states had been identified as problem physicians by the PRO and at least one other review entity.

²California has two carriers, but we reviewed only Blue Shield of California, which covers the northern part of the state. Similarly, Virginia has two carriers. We reviewed Travelers Insurance Company, which covers all areas of the state except for counties and cities in the Washington, D.C., metropolitan area.

Review Entities Do Not Routinely Exchange Information About Problem Physicians

Although PROs, carriers, and state Medicaid agencies often review the same physicians, officials of these entities told us that they do not routinely exchange information on those physicians found to have problems. We believe that such an information exchange could enhance the effectiveness of the review function.

As stated earlier, one of the primary objectives of the review function performed by PROs, carriers, and state Medicaid agencies is to protect program beneficiaries from receiving—and prevent Medicare and Medicaid from paying for—unnecessary or poor-quality health care. One way to accomplish this objective is to identify physicians who provide such care and change their behavior through education, other corrective action, or sanctions.

One of the primary benefits of information exchange among review entities would be early identification of problem providers, which would enable the review entity to institute prompt corrective actions. For example, a Virginia carrier official told us that in late 1985 she had requested the PRO to review a case involving a physician suspected of providing poor-quality care. However, because HCFA has not required PROs and carriers to routinely exchange information or work together on such matters, the PRO informed the carrier that it would have to refer the case to HCFA, which could then refer the case to the PRO for review. The carrier official decided not to pursue the request.

Through its independent review, however, the PRO later identified a number of instances of unnecessary and poor-quality care provided by the same physician. During the period August 1986 through February 1988, the PRO denied payment for 16 of the physician's 307 Medicare hospital admissions, and found 39 quality problems (27 minor and 12 major) associated with the care provided to Medicare inpatients. The PRO placed the physician under intensified review in September 1987, and subsequently required him to accept a corrective action plan. Had there been a mechanism for information exchange between the carrier and the PRO, the physician in this case may have been placed under intensified review and required to begin corrective action perhaps as much as one year earlier.

We found one example where information provided by a carrier to a PRO enabled the PRO to identify a problem physician earlier than would have been the case otherwise. The North Carolina carrier referred a case to

the PRO that involved an invasive diagnostic procedure,³ which resulted in complications that may have contributed to a patient's death. According to the PRO officials, the case in question had been selected for review as part of the PRO's random sampling process. The case had not yet been reviewed, but was given priority because of the referral from the carrier.

The PRO found that a noninvasive diagnostic procedure might have been substituted for the invasive one, thus avoiding the possibility of complications. The PRO notified the responsible physician of its findings, and warned that any additional significant quality-of-care problems would lead to further review of his file. A PRO official pointed out that the carrier referral ensured that this case would have been reviewed, regardless of whether it had been included in the random sample.

Data Exchange Desired by Entity Officials

Officials of the entities we reviewed generally agreed that routine information exchange would help them carry out their responsibilities more efficiently. PRO officials in the three states we visited said that information about problem physicians from Medicaid agencies and carriers would allow them to intensify their reviews of such physicians and to focus on the types of problems observed by the other entities. PRO officials in two states also said that such information would be particularly important if a physician were treating a small number of Medicare beneficiaries, because without such information the PRO might review few, if any, of the physician's cases.

Officials at all three of the carriers and two of the three state Medicaid agencies we visited told us that exchange of information with PROs on problem physicians would be useful. An official of the Virginia Medicaid agency said that, based on his discussions with us, he had initiated contact with PRO officials regarding the possibility of future exchanges on a regular basis.

Data Exchange Not Prohibited by Statute

We found no statutory provision that would prevent carriers or state Medicaid agencies from informing each other or PROs of physicians identified as providing unnecessary or poor-quality care. Furthermore, HCFA

³A procedure, such as a cardiac catheterization, that involves penetration of the body by a diagnostic instrument through a natural or artificial opening. A noninvasive diagnostic procedure, such as an X-ray, does not involve such penetration.

regulations specifically permit carriers to release information to state Medicaid agencies on physicians being investigated for fraud and abuse.

With respect to PROs, section 1160 of the act generally prohibits them from releasing any information gathered in the exercise of their duties and functions under pain of criminal penalties. However, the section provides for numerous exceptions. For example, PROs may disclose information to the extent that such disclosure may be necessary to carry out the purposes of the act's PRO provisions.

In addition, PROs may disclose information where provided for in regulations in order to ensure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. This would permit the Secretary to arrange for PROs to exchange information with carriers and state Medicaid agencies consistent with section 1160.

Furthermore, section 1154(a)(10) of the act requires PROs to coordinate activities, including exchange of information "consistent with economical and efficient operation of programs," with Medicare intermediaries, carriers, other PROs, and other public or private review organizations as may be appropriate. These provisions lead us to infer that the Congress expected such exchanges to occur.

Actions Taken by HCFA

HCFA has taken several steps to require PROs to supply information to state licensing boards on physicians providing unnecessary or poor-quality care. For example, on March 16, 1988 HCFA proposed amending its regulations implementing section 1160 of the act to, among other things, require PROs to routinely disclose information to licensing boards and accrediting bodies at the time that they submit a sanction report to the OIG.

In addition, by including a related provision in the scope of work for the 1988 PRO contracts, HCFA has, in effect, already required PROs to routinely supply such information to state licensing boards when serious problems are identified.

HCFA is currently preparing instructions for PROs covering confidentiality and release of information. The draft instructions that we reviewed would permit PROs to release certain information about providers if requested by carriers and intermediaries or state fraud and abuse agencies. The instructions do not, however, provide for the routine exchange

of data among PROS, carriers, and state Medicaid agencies on physicians who provide unnecessary or poor-quality care.

Conclusions

Information exchanges among PROS, carriers, and state Medicaid agencies could enhance their ability to identify and deal with physicians and other providers furnishing unnecessary or poor-quality care to program beneficiaries. Such exchanges are not prohibited—indeed sections 1154 and 1160 of the act suggest that the Congress intended that exchanges take place. HCFA has recently taken a step in this direction by requiring PROS to furnish information on problem physicians to state licensing boards. We believe that HCFA should take similar actions to require PROS, carriers, and state Medicaid agencies to exchange information regarding physicians providing unnecessary or poor-quality care.

Recommendation

We recommend that you require PROS, state Medicaid agencies, and carriers to routinely exchange information about physicians who provide unnecessary or poor-quality care. This could be accomplished through regulation and by including provisions requiring such exchanges in PRO and carrier contracts, requiring similar provisions in Medicaid state plans, and giving guidance to these entities clarifying the conditions under which such exchanges are permitted.

Agency Comments

We did not obtain written agency comments on this report. However, we discussed its contents with HCFA officials and have incorporated their comments where appropriate. These officials generally agreed that exchange of information among review entities would be beneficial. They told us that HCFA's Directors of the Health Standards and Quality Bureau and the Bureau of Program Operations had agreed to explore options for exchange of information on poorly performing providers between Medicare carriers and PROS. Although they intended to encourage state Medicaid agencies to participate in such exchanges, HCFA officials, however, did not believe that Medicaid agencies should be required to exchange information with carriers and PROS. They stated that Medicare and Medicaid had different standards for assessing quality of care and thus, in some cases, problems found by Medicaid agencies might not be relevant to Medicare.

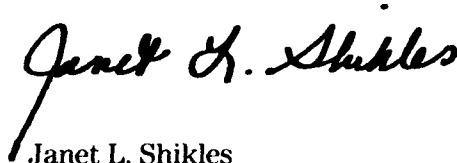
We continue to believe that state Medicaid agencies should be required to participate in exchanges of information on problem providers. It is true that in some cases problems found by state Medicaid agencies might

not be directly relevant to Medicare review entities, and vice versa. In such cases, however, the receiving entity could evaluate the information received and determine what action should be taken.

As you know, 31 U.S.C. 720 requires you to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs within 60 days of the date of the report, and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the four above-mentioned committees, other interested congressional committees, and others on request. Should you have any questions regarding this report, please call me on (202) 275-5451. The other major contributors are listed in appendix I.

Sincerely yours,



Janet L. Shikles
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